



Differential response to depression prevention among a sample of informal caregivers: Moderator analysis of longer-term follow-up trial data



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ABSTRACT

Depression is one of the most common mental disorders in caregivers. Therefore, preventive interventions for this population are needed, especially for caregivers with subclinical symptoms of depression. However, no study to date has identified the characteristics of caregivers that help to predict who will or will not benefit from such a preventive intervention. This study aimed to identify moderators of response to intervention comparing problem solving and usual care in indicated prevention of depression among informal caregivers. A randomized controlled trial was conducted involving 173 participants who were allocated to the problem-solving intervention ($n=89$) or the usual-care control-group ($n=84$), with 12-months follow-up. Socio-demographic, care-related and clinical variables at baseline were analyzed as potential moderators of intervention response at 12-months follow-up. Age and emotional distress emerged as significant moderators. Those caregivers younger than 65 years and with higher emotional distress at baseline were more likely to benefit from the intervention than from usual care. Simultaneous consideration of multiple moderators found that intervention was indicated for 95.4% of the sample. Considering these moderators in clinical decision-making could contribute to matching treatments and health service users in a more personalized and effective way.

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1. Introduction

Long-term care is a challenge in high-income societies due to the unprecedented demographic changes related to the aging of the population and the new family structures (Colombo et al., 2011; Social Protection Committee and the European Commission, 2014). Currently, informal care represents the bulk of the care provided (Colombo et al., 2011; Naiditch et al., 2013) and is mostly shouldered by women (Colombo et al., 2011). However, there is evidence that caring for a dependent individual (e.g., a partner, relative or friend) in an unpaid manner can mean exposing oneself to life events and daily problems such as interference with social

activities and work (e.g., Clark and Bond, 2000; Colombo et al., 2011). These interferences can negatively impact the caregiver's mental health. In this context, one of the most common mental disorders observed in caregivers is depression, with a prevalence of 8.9% (Torres et al., 2015).

According to the etiopathogenic model of depression by Nezu et al. (1989), depression is a dynamic process that changes in intensity and nature depending on an individual's major life events, current problems and their problem-solving coping activities. A number of studies have provided evidence of the mediating and moderating effects of problem solving between negative life events and everyday problems on the one hand and depression on the other (see D'Zurilla and Nezu, 2010 for a review). This suggests that training in problem-solving skills may lead to a reduction in depressive symptoms. Problem-solving therapy has proven to be

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effective as a treatment for depression (Bell and D'Zurilla, 2009). Indeed, problem-solving therapy is one of the therapies recommended for depressive disorder by the National Institute for Health and Clinical Excellence (2010).

However, given the high prevalence of depression, to solely rely on treatment might prove to be a suboptimal health care strategy from a public health perspective. The resources necessary to support affected people are limited, and not everyone in need uses these resources (Cochrane et al., 1997). Even among depressed people who do receive treatment, only one third of the burden associated with depression can be reduced by applying currently available evidence-based treatments (Andrews et al., 2004). Therefore, a promising line of action is to offer preventive programs to reduce the incidence of depression. Indicated prevention (i.e. directed to people with subclinical symptoms not yet meeting the diagnostic criteria for depression) is particularly relevant, because subclinical depressive symptoms are one of the main predictors of depression (Cuijpers and Smit, 2004).

Various interventions for caregivers have been developed. The interventions focus on psycho-educational, psychosocial and respite interventions (Garcés et al., 2010) and are targeted specifically to caregivers of people with dementia (Goy et al., 2010). Given that dementia patients are a substantial share of the long-term care recipients and tend to require constant care, a lot of demand is placed on their caregivers (Colombo et al., 2011). But despite the recommendation to select samples of caregivers with specific risk factors for mental health problems (Zarit and Femia, 2008), only one randomized controlled trial (RCT) on indicated prevention for depression targeting this population has been conducted (Vázquez et al., 2013; Otero et al., 2015). This study was based on the etiopathogenic model of depression by Nezu et al. (1989) and it documented the short term (Vázquez et al., 2013) and long term (Otero et al., 2015) efficacy of this type of intervention.

Nevertheless, the fact that an intervention yields favorable effects on average does not preclude the possibility that identifiable subgroups of patients may benefit more or not at all from that intervention (Kravitz et al., 2004). These differences in treatment response are important to consider when people are being referred to such interventions (e.g., Fournier et al., 2009; DeRubeis et al., 2014).

In this context, two types of parameters are relevant for identifying differential response to intervention: (1) prognostic variables or predictors (i.e., variables that help predict a patient's outcome); and (2) prescriptive variables or moderators (i.e., variables that can help identify individuals who are likely to benefit or who will not benefit from a particular intervention; cf. Kraemer et al., 2002). The identification of moderating variables may help to optimize the matching of treatments with individual patients, and can be seen as the ultimate goal of personalized medicine (Simon and Perlis, 2010).

In recent years, research has become more focused on these issues and moderators have been examined in some studies of indicated prevention of depression in different populations (e.g., Seligman et al., 1999; Stice et al., 2010; Korte et al., 2012). However, to our knowledge, no study to date has analyzed which are more appropriate interventions to prevent depression in specific groups of caregivers. The goal of the present study is to identify moderators of response to preventive intervention of a problem-solving intervention (PSI) as compared to treatment as usual (TAU) in indicated prevention of depression among informal caregivers. It is expected that baseline socio-demographic characteristics, as well as the general conditions surrounding caregiving activities and clinical variables are putative moderators of treatment effects.

2. Methods

The present paper represents a secondary analysis of a previously reported RCT comparing PSI to TAU. Methodological details have been described elsewhere (Otero et al., 2015). Important features of the methods used are highlighted below.

2.1. Participants and procedure

Participants were recruited from the official registry of informal caregivers through an agreement with the Ministry of Labour and Welfare of the Galician Regional Government (Spain). Eligible participants were those with subclinical depressive symptoms, with scores 16 or higher on the Spanish version of the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977; Spanish version of Vázquez et al., 2007) and no history of major depression. Exclusion criteria included: psychiatric or pharmacological treatment received in the two months prior to study entry; disorders that could confuse results or require immediate medical attention (dysthymia, bipolar disorder I and II, cyclothymic disorder, anorexia, psychotic disorders, alcohol or substance dependence, panic disorder, obsessive-compulsive disorder, somatization disorder, hypochondriasis); psychological or medical conditions requiring immediate intervention or impeding the normal development of the study; simultaneous participation in another study; terminal illness in the person to whom they were providing care; expected change of residence or expected admission of their dependent to in-patient care.

Four hundred and one subjects were initially evaluated in this study. Of these, 176 (43.9%) fulfilled the eligibility criteria, and of these, 3 (1.7%) declined to participate in the study. One hundred and seventy three participants were randomly assigned by an independent statistic using a random number table to either a problem-solving prevention intervention group ($n=89$) or a control group receiving usual care consisting of community-based care ($n=84$).

Table 1 summarizes the sociodemographic, care, and clinical variables of the participants. The final sample had a mean age of 53.9 ($SD=9.2$). The proportion of caregivers that had completed primary education or higher was 75.1%, most (84.4%) were unemployed and 67.6% had two or more children (indicating additional family responsibilities besides the person in a dependent situation). For 50.9% of participants, the person receiving care was their mother or father, and the average length of caregiving was 9.5 years. Five caregivers (5.6%) from the intervention group and three (3.6%) from the control group abandoned the study. Attrition was unrelated to experimental condition.

Participation was voluntary, and there were no incentives, financial or otherwise. The study adhered to the most recent revision of the Helsinki Declaration and was approved by the Committee for Ethical Research of the University of Santiago de Compostela, Spain. Informed consent was obtained from each participant after a complete explanation of the nature of the study.

2.2. Interventions

2.2.1. Problem solving

The intervention group received a brief cognitive-behavioral intervention in group-format, based on the etiopathogenic model of depression proposed by Nezu et al. (1989) and directed to train problem-solving skills. Before the intervention, a treatment protocol was designed and formalized into a manual, and a pilot study was conducted (Vázquez et al., 2010). The intervention included five sessions, once a week over five weeks, each approximately one and a half hour long, with approximately five participants. In the first session, the concept of depression, the problem-solving model

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